

# Creating an Integrated, Consumer Centered Care Team

*Completed in 1996, this report describes the planning, initial development, and evolution of the interdisciplinary care team. It discusses in detail the complexities involved in providing consumer centered care in an integrated (health and long term) care setting.*

*Based on these findings, the interdisciplinary care team curriculum, Providing Consumer Centered Care in Integrated Programs was developed in 1997, and piloted at several Partnership sites in 1998 and 1999.*

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## **Introduction**

The Partnership Program has, from its inception, espoused a commitment to providing high quality, patient-centered, comprehensive and non-fragmented care. While there has always been consensus among the Partnership designers, evaluators and staff about the importance of doing this, there has been no such consensus about the meanings and implementation of these commitments. Ongoing research on the development of the Partnership Program has revealed that high quality, patient-centered care has many meanings depending on whether it is defined from the perspective of patients, families, nurses, social workers, regulators, or others. The definitions of both ‘high quality’ and ‘patient-centered’ care varied in predictable ways across these groups.

The purpose of this report is to describe the planning, development, and evolution of the Partnership Team Model, using the Partnership demonstration project as a means to identify both the nature and impact of an integrated, collaborative, patient-centered, interdisciplinary team.

## **Data Collection**

A process of ongoing data collection, including both participant observation and interviews with providers and recipients of care, was used. The focus of data collection

efforts was to understand the multiple definitions of quality and patient-centered care being provided by all program participants (consumer, administrators, providers). This required a continuous and simultaneous data collection/feedback mechanism which could illuminate and explicate each participant's perspective on what was meant by 'quality' and 'patient-centered', as well as whether or not it was being provided by the team. The Partnership Team differs from most other interdisciplinary teams in several important ways. First, the team attempts to integrate health care and social services practically and conceptually. Second, the team is responsible for the care of participants across multiple settings. Finally, the team strives to build consumer perspectives into the creation, evolution, and evaluation of team functioning. Achieving these goals required the research team to become active members of the community; involved in multiple committees, workgroups, program development processes, and operational meetings. The ability to participate in the development of the project while interviewing staff, recipients of care, and other providers in confidential, one-on-one or team interviews, gave the researchers a privileged view of front and back stage interactions, public and private conversations, as well as concerns, fears, expectations, and reservations. It also provided a clear view of how 'back stage' concerns, tensions, and conflicts were framed in various settings, how this evolved over time, the significance of such concerns for the provision of

high quality, patient-centered care, and how the evolution of the team was processed, as well as implemented, by individuals and by the team.

Group interviews were also used to collect data on the evolution of the team. These interviews were primarily ‘natural’ clusters rather than researcher constructed, e.g. focus groups. Natural groups included: primary care teams, professional practice groups, quality assurance work teams, worker specific task forces to review recruiting, training, supervising, and retaining strategies, and other work groups created for operational purposes. Later in the process, focus groups were conducted to explore specific issues in greater detail.

## **INTEGRATING HEALTH CARE & LONG TERM CARE: CHOOSING A MODEL**

An initial challenge for the Partnership Design Team was to decide how to construct a team model integrating health care and long term care while minimizing fragmentation and maximizing quality. Additionally, there was a challenge to examine exactly what each of these disciplines bring independently and as a collaborative team. Differences in and disputes over how to conceptualize both ‘quality care’ and ‘patient-centeredness,’ as well as the appropriate strategies for their implementation, occurred early in the Partnership team development process.

In particular, the differences between nursing and social work professionals about the meaning of patient- or consumer-centered care, and what should be used as evidence for high quality care, were reflected in initial interviews with professionals from each discipline. It was clear that team members were using similar language to express very different concepts, and were bringing in discrepant assumptions. The expression of very different meanings through common language was often interpreted (by the other person/discipline's) as deception, ignorance, naiveté, and/or arrogance or unwillingness to listen.

These differences in meanings, and the conflict often resulting from them, were observed outside the Partnership Program as well. Differences in meanings and assumptions were most pronounced between health care providers with experience in acute care or skilled home care roles, and social service providers located in community settings. They were found wherever nurses and social workers were attempting to define their roles in relation to each other and to the patients/consumers they served.

Negotiations between the Partnership Program staff and agencies in the larger community that provided health care and/or social/supportive services repeatedly engaged in conversations, conflicts, and strategies that reflected a mismatch among the various groups in the definition of these terms. One of the greatest challenges for the development and effective operation of the Partnership team was identifying, coming to terms with, and

appreciating and making effective use of these differences and the opportunities, not just difficulties, created by them.

Taking these discrepant views into consideration during the planning phases of the project, the Partnership Design Team deliberately designed the program so that care management would have to be done collaboratively, by an interdisciplinary team. Team members would be forced to collaborate so that it would be possible to examine the impact of combining the health care and social services disciplines rather than choosing between them, or dividing the labor between them. The Design Team was also committed to doing this in a way that was not simply creating redundancy or facilitating fragmentation. This is consistent with the overall project goals.

### **Integrated, Interdisciplinary Care Management**

Developing a team model of care grounded in care management required the Partnership Design Team to decide what model of care management would be used. The Design Team selected an integrated model for several reasons. First, the combining of funds from and the acceptance of responsibility for both health and long term support requires a program that cuts across the domains of health and social services. Health care providers do not, as a group, have expertise in long term support. Social workers do not

have, as a group, expertise in managing health and health care. Therefore, expertise from both domains and both groups was needed.

Second, the problems experienced by recipients of care (both elderly and physically disabled) could not be neatly defined as 'social work issues' or 'nursing issues.' The Design Team believed that many of the conflicts, as well as their solutions, demanded a response that reflected a hybrid of disciplines and related expertise. Consequently, most individuals would benefit from the collaborative intervention of both nursing and social work disciplines, even if consumer needs tended to be predominantly in one domain or the other at the time of the initial assessment. While there was some overlap between areas of expertise, neither discipline could substitute for the other without compromising the quality of care.

Third, it was hoped that a collaborative model of care management with a shared documentation system would reduce fragmentation and redundancy of care. Making decisions jointly and documenting these decisionmaking processes would enhance the information each discipline had about what the other discipline was engaged in and prevent redundancy and gaps in care. Where disciplines overlapped in their expertise, collaborative decision making would minimize both duplication and the occurrence of multiple, divergent approaches to the same problem. Joint decision making would reduce

the possibility that each discipline might think the other was responsible for addressing the problem, while neither discipline was actually doing so.

Fourth, collaboration would ideally force interdisciplinary discussions about how to prioritize the interventions selected and the resources used, rather than create conflicts in which each discipline advocated use of limited funds for the problems most relevant to their own area of focus. This would provide an opportunity to watch how these disciplines could inform each other and what difference this might make for care.

Fifth, there was concern expressed by social service staff on the project (and in the wider community) about the consequences of shifting authority for the expenditure of long term care funds from the social services network to one that combined health care and social services. Many in the 'aging network' believed that this could result in a dominance by the health care providers, an overmedicalization of long term care, and a depletion of the resources available for non-medical support. Simultaneously, clinical staff insisted that the level of frailty and the complexity of health concerns required a close and consistent involvement of skilled health care providers. This was particularly true for the frail elderly. Both of these concerns were addressed in the Partnership team model. The Partnership demonstration could be used to study this process, identify whether and how it occurred, and the means to maintain a more balanced approach.



Finally, collaboration between nurses and social workers on the team was seen to have the greatest potential for bringing insights, experience, professional connections, and knowledge about the continuum of settings in which consumers/patients can be found. Experts from within each domain and setting would be brought together in place of the customary practice of referral. This, it was hoped, would enhance the ability of the team to interact with other providers involved in care across an array of settings. This, it was hoped, would reduce fragmentation and discontinuity from one location or provider to another. Consequently, models of interdisciplinary teams that divide decision making and/or accountability, or that allow the shifting of cost and/or accountability, were rejected. ***Rejected*** team care models included:

#### **Case Load By Discipline**

*Dividing care of consumers/patients into those most appropriately followed by one or the other discipline based on assumptions about where the consumers' greatest need was likely to be.*

The Design Team considered this unsuitable since the model presumes that individuals have primarily either health care or social service needs. The Partnership Program design team assumed that increasing needs in one of these two areas frequently corresponds to increasing needs in the other.

#### **Case Load By Setting (referrals)**

*Dividing care into community and institutional settings by discipline.*

Long Term Support is primarily the domain of social work. Institutional and ‘skilled’ (home care) is commonly the domain of nursing. Such a referral system results in either primary accountability in one, rather than the other discipline (rejected above) or accountability in neither, where the lead role switches as the patient moves from one system to the next.

A hazard with this system is that a failure to provide adequate care (a poor outcome) often leads to a shift to another system. This prevents the system in which the poor outcome occurred from having to take care of or even be aware of the failure. The referral model also assumes that care managers have enough expertise in the other disciplines to realize when a referral is indicated. This relies on the care managers' ability to detect early, subtle indicators of difficulties in areas outside of their expertise. A successful referral model also depends on the ability and willingness of providers to communicate effectively with each other.

### **Shared Case Load/Parallel Work**

*A multidisciplinary model that brings disciplines to the table after they had already formulated a plan for addressing problems separately discovered during their own assessments.*

In this model each discipline relies primarily on their own assessments. This model, although widely in use in health care settings, perpetuates a division of labor rather

than a true collaboration. Team members generally come to the table to report conclusions and make recommendations based on their independent assessments.

### **The Compromise Model**

*Divide the available funds equally between health and long term care services.*

In this model, neither group would use more than some predetermined 'fair share' of the total resources. It was believed by those who suggested this approach that it would prevent the dominance of health care over long term care. This last suggestion reflects the general fear and common reality that health care providers have a greater influence than other providers on interdisciplinary team decision making. Social service providers were willing to accept fewer resources in exchange for a more separate, less interdependent working relationship.

Critics of a collaborative, interdependent model suggested that the team members could 'work together' by working in separate offices, staying within a predetermined resource limit, and being accountable for a separate domains of services. While this would likely minimize the conflicts between team members, it would also allow the team members to appear as if they were collaborating while actually maintaining a comfortable separation. This model could easily result in shifting accountability for both cost and quality. Care and services would also continue to be fragmented under such an arrangement.

## **BUILDING THE PARTNERSHIP TEAM**

The Partnership Design Team made a commitment to a model that was both conceptually and practically integrated. Decisions about how to structure, supervise, house, recruit and operate the team were guided by the assumption that smooth team functioning was only possible if the discipline related differences in perspectives were addressed and resolved. How the team would be created, nurtured, and what the consequences of an interdisciplinary approach would be were questions that could only be answered by the demonstration. A central focus of the research/evaluation, therefore, was to explore the feasibility and complexity of integrating health care and social services and to examine the consequences of doing so.

The Partnership Design Team recommended a model in which the team, rather than an individual, acted as care manager. The team was the unit responsible and accountable for decisions about how expenditures would be made and the outcomes achieved. The team would report as a unit to the administration, rather than each team member reporting through a separate line of authority. Resources would be assessed by the team rather than specified for specific disciplines. Nurses and social workers were to be co-located in order to maximize opportunities for interactions between the disciplines.

Accountability for costs, processes and outcomes would be shared rather than divided into disciplines specific domains.

## **NURSING AND SOCIAL WORK**

Differences between how social workers and nurses discussed care management were discovered in early interviews with representatives of both disciplines. These differences were heard on multiple occasions, reverberating throughout the demonstration, and are clearly consistent with each discipline's literature on the topic.

These differences relate to:

- the definition of patient/consumer centeredness (quality, life/care, choice, outcome)
- the degree of standardization or practice guidelines
- the nature of accountability (patient standard, quality)
- the evidence of success and failure (patient v. provider outcomes, quality)
- the parameters or boundaries of practice (being a professional)
- the nature of relationships to other providers (advocate)
- the determination of needs
- the visibility of practice (intrusiveness)

Differences between the two disciplines on these points often resulted in one discipline seeing the other as unrealistic, uninformed, and not acting in the

consumer/patients' best interests. The outcome of these disagreements was to promote fragmentation. These disputes were the sources of what is often referred to as 'values conflicts' and contested definitions of patient-centered and quality care.

## **LONG TERM CARE SETTING**

### **Social Workers as Consumer-centered**

Social workers described consumer-centered care as promoting self determination, consumer choice, and recognizing and respecting the uniqueness of each individual. This philosophy mitigates against efforts to standardize either interventions or outcomes since doing so involves minimizing or even eliminating those individual differences that social workers are often engaged in promoting. The use of the word 'consumer' itself suggests an active, as opposed to a passive recipient role. The social worker is the promoter and the facilitator of consumer choices and preferences.

Early in the development of the Partnership Program, social workers maintained a vigilance over health care workers (nurses in particular), concerned that their health care colleagues were not adequately 'patient-centered' and tended to impose their will on patients. Social workers believed that there was an absence of patient-centeredness in nursing practice that:

- defined nursing practice as provider-centered instead of patient-centered

- defined goals FOR their patients rather than letting participants define goals
- used similar interventions for all patients with a particular problem, not individual differences
- made decisions for patients rather than offering choices to patients
- seemed to view needs as predetermined by the medical problem rather than the patients particular situation and preferences
- did not view patient disapproval as necessarily reflecting on the quality of care, finding colleague evaluation and external reviews adequate
- considered patient 'compliance' with the nurse' plan to be a central goal,
- tended to compromise a patients quality of life when safety was an issue rather than supporting the dignity of risk
- remained aloof and detached from their patients

Care management grounded in a social work philosophy demands a process of determining what ends will be pursued, what goals will be attained, and what outcomes are desirable. This process is directed by the consumer and facilitated by the social worker. Goals and outcomes are, therefore, necessarily as diverse as the consumers themselves. Outcomes cannot be predetermined as they await definition by the negotiation between care manager and each new consumer. It follows logically, therefore, that the social worker is primarily accountable to the consumer. While there may well be

other forms of accountability to colleagues or supervisors, the participation of each consumer in defining what is needed and what is a good outcome makes the consumer's participation central to the outcome.

### **Standardization**

Standards and externally imposed criteria are necessarily of secondary consideration in the process of determining a 'good' outcome, hence high quality service. The intense process by which social workers (as care managers) accomplish this is outlined in a study of 'the best' care managers in the Wisconsin Long Term Support Network (Bowers, 1995). Six care managers, Defined by peers, supervisors, and regulators as 'the best,' described the strategies they use to remain focused on what the consumer identifies as a good outcome. They described how this process requires them to continuously adapt services and resources to meet the needs and preferences of individual consumers. While there were at least implicit references to theories and standards guiding their decisions, these were never described as sufficient, and rarely seen as central to the decisions about a particular individual. These findings are validated by the interviews with social workers in the Partnership Program.

## **HEALTH CARE SETTING**



Being patient-centered is clearly understood and operationalized quite differently by nurses than by social workers. The literature in health related areas, including nursing, addresses patient-centered care conceptually and practically in a very different way. Historically, health care providers have been primarily accountable to a philosophy and practice guided by 'doing no harm' and mobilizing resources to promote or return patients to the best possible state of health.

The nature of the work, and the problems addressed by its practitioners, often requires a high level of technical expertise, including an understanding of the problem as it occurs across patients. The broader the experience with 'similar' cases, the greater the ability of a practitioner to anticipate and recognize the subtle indicators of amelioration or deterioration. The gaze is therefore, always in the context of the experience other patients have had, the courses that other patients have traveled, and what indicated and promoted successes and failures in past treatments. This is a process of viewing the particular patient in the larger context of all similar patients, in order to provide the highest quality of care. Expert knowledge is derived from experience with others. The larger the group of 'others' and the greater the practitioners experience with similar cases, the better able the practitioner is to guide and advice the patient. Quality of care in health care settings is, therefore, quite logically determined by standardized outcomes based on a clearly defined domain of expertise.

## **Nurse as Patient-Centered**

Nurses work to return patients to health or the healthiest possible state. When health is not attainable, this goal is replaced with optimal functioning and the prevention of complications and side effects when possible. In general, nurses agreed with social workers that it was important to take the patient's perspective 'into consideration.' However, nurses viewed social workers as often 'giving up' control (to the consumer) over decision making. In general, nurses described social workers as unrealistic, as overly patient-centered, and as unable to balance the consumer's views or desires within a context of professional expertise. They described social workers as:

- often 'unrealistic'
- not able to distinguish what a patient wanted from what a patient 'needed'
- tending to give patients whatever they ask for even if it isn't in their best interest
- promoting the interests of an individual at the expense of the larger group
- not able to appreciate the need to prioritize interventions in response to the medical urgency of a situation (since they are not accustomed to dealing with 'real' emergencies)
- often emotionally overinvolved, obscuring professional boundaries, and becoming ensnared in (rather than intervening in) problematic family dynamics

- often siding with consumers over colleagues
- seeing themselves as 'the advocate', which implies that no one else is
- 'unrealistically' ignoring risks, and unable to identify health problems before they become advanced.

### **Standardization**

Practitioners are primarily accountable to standards developed by other professionals and based on a distillation of large numbers of cases. Standardization and professional accountability are important means of assuring that providers maintain adequate knowledge and treat medical problems. In an effort to raise overall standards of practice in health care, there has recently been an increased focus on developing standards for both interventions and outcomes, and on developing mechanisms to hold individuals, organizations, and disciplines accountable for them.

This accountability to externally imposed standards of practice directs the gaze of providers and organizations to external review bodies, both governmental and professional. This leaves little room for the patient to influence the course of events, or to define desirable outcomes. The patient is introduced as an evaluator of quality only when organizations ask patients about their level of satisfaction with the services provided. Even then, however, patients are in a position to respond rather than to define what was

satisfactory or not. While these satisfaction surveys provide important feedback about patients' reactions to the organization, the providers, the staff, the services, and the amenities offered, they do not invite or allow patients to define the questions.

The logic of this model is sound, within the realm of technical and professional expertise. However, it collapses in the context of patient choice about outcomes, alternative treatment decision by experts who cannot determine outcomes with certainty, and settings where illness, disability, and treatments collide with other important life activities.

### **THE VALUES CONFLICT**

Recognizing these important differences between nursing and social work, and the impact of these views on building a team, it was necessary to make sure each discipline understood how the other discipline's assessments were arrived at. Having this understanding would diffuse the hostility, facilitate and appreciate communication, and create the possibility for any real collaboration. For true collaboration to occur, it was necessary to evolve from the starting point of conflicting viewpoints, through tolerance, and on to a real appreciation of what each discipline had to offer the other, and together, what they could provide to the patient. This meant directly confronting the 'values conflict' inherent in each discipline's perception of each other, seeing each of these

perspectives in the context it grew out of, and appreciating the significance of each for team functioning and patient care

The common focus between the nursing and social work disciplines was that both strived for the patient's best interest. However, one operates from the assumption that the provider has the greatest ability to assess the nature of the problem and determine the most appropriate solution, moving the patient in the direction of better health or functioning. The other operates from the assumption that the patient can make decisions about risk, priorities, and the appropriateness of care for him or herself. There are inherent risks either way.

It is difficult to argue with the assumption that the health care provider generally possesses greater technical expertise and better knowledge of treatment options than the patient/consumer. However, this explanation does not justify excluding the patient from decisions about personal preference, choice of setting for receipt of care, degree of risk to be taken, priorities for intervention, tolerance or intolerance of specific side effects, and tradeoffs between complying with care requirements and engaging in activities that compete with such compliance.

In fact, these decisions rely on direct participation of the patient, or the participation of a decisionmaker on behalf of the patient, who is familiar enough to do this well. Doing this well requires 'biographical' expertise. This decisionmaking process

cannot be abstracted from professional knowledge or experience with large numbers of 'similar' cases. Patients must have access to technical experts and professionals with considerable experience and wisdom in order to make an informed choice.

While one approach focuses on maximizing self determination and choice, the other focuses on maximizing healthy outcomes, and preventing complications by enlisting the patients' cooperation in the plan of care. Together they can locate the care plan that is technically sound and appropriate in this instance.

### **DETERMINING NEED**

The process by which need is determined differs conceptually and practically between the nurses and social workers observed on the Partnership Teams. An important component of need determination is the response to the question: *Need in order to accomplish what end or in the service of what outcome?* Answering this question incorporates the assumptions already discussed about accountability (to whom or what). Neither the process by which need is determined, nor the assumptions about accountability, are shared by these two disciplines. What frequently occurs is a competition between two very different conceptualizations of needs, arrived at through very different methods, and implying quite different, and sometimes incompatible, interventions.

## **Nursing**

Nurses often made distinctions between what patients said they wanted and what they needed to regain health. [This distinction was generally rejected by social workers since it privileges the nurse's view over that of the patient's.] Nurses saw this as a useful distinction since patients sometimes wanted things that were in clear contradiction to, or at least not consistent with, what was needed to regain health. The distinction between want and need also seemed to arise from a world view of scarcity. The nurses often responded from a zero-sum view of the world, constantly factoring in an acknowledgment of resource shortages.

In health care settings, patients are invited and encouraged to participate in their care, although they were not generally asked to participate in the definition of what was needed to return them to an optimal level of health and functioning. These decisions were seen as based in expertise on illness and treatment, and consequently, had to come from health care providers. Gaining access to this expertise was, in fact, the reason that patients consulted with health care providers. Health care providers rather than patients have knowledge about illness and treatment. Patients do not have the knowledge to determine what they need to return to health and must therefore rely on the expertise of

health care providers. Therefore, asking patients to participate in determining what is needed would not be a sensible approach to solving such a problem.

### **Prevention**

A major component of prevention involves the protection of the patient from hazardous and predictable problems resulting from the illness or its treatment. This leads to a constant monitoring of the signs and symptoms related to illness progression and the side effects of treatment. Having observed those hazards, and their consequences in others, nurses remain vigilant and ready to react quickly to the occurrence of precipitating factors and the signs of impending problems. This generally requires action on behalf of, rather than at the behest of, the patient.

Social workers felt disadvantaged by the nurses ability to use the safety and urgency of the nurses assessment as a priority. This often left social workers in the position of knowing that the consumer defined need/s they had put on the table, that were important to the consumer, were not getting a fair hearing. In response to this, social workers believed that a consumer advocate was required.

## **DETERMINING NEED**



## **Social Work - Advocacy**

Social workers who were members of the initial PACE and Partnership Teams, as well as social workers in the community, were interviewed about their views of good care management. During these interviews frequent references were made to their role as a consumer advocate. This was often identified as what set them apart from other disciplines. Social workers described themselves as using their skills and networks to obtain what consumers wanted and needed and as speaking on behalf of consumers who were unable to do so.

There was a pervasive perception within this group of professionals that health care and other services were difficult to access, not consumer sensitive, and that a strong consumer advocate was necessary for consumers to accomplish their goals, meet their needs, or attain a decent quality of life.

Analysis of interviews with social workers suggests that this experience becomes defining of the consumer/social worker relationship. The shared quest for needed services, as well as the success and failures that mark the way, can create a strong bond. This closeness frequently results in a much greater level of familiarity than is generally the case between health care providers and their patients.

In order to be a successful advocate it is necessary to become close enough to the consumer to view the world from the consumers perspective, to understand and appreciate

the consumers experience. This familiarity is best achieved through a relationship that endures over time, through crises, relies on the sharing of intimate details about the consumer, depends on and promotes trust in the provider, and adapts or subverts systems and rules to accommodate the needs of the individual consumer.

In such a situation, the consumer is empowered to make decisions about their life and is encouraged to choose from a wide array of options in an effort to obtain the desired end. This necessarily places the responsibility for defining needs and desirable outcomes with the consumer.

### **Consequences for Social Worker as Advocate**

Maintaining a focus on needs as defined by the consumer gave the social worker a close up view of the gaps between what is 'needed' and what is available or even possible. In many instances the only strategy for closing this gap was for the social worker to actually provide the service. Thus, there were instances observed when social workers provided transportation, shopping, and even friendship, that would otherwise not have been forthcoming.

The ever-present risk here is that the demand for services in a system characterized by scarcity and access restrictions is endless. With no restrictions on the relevant domains, meeting the consumer's needs can take many varied forms. A second risk (not universally

considered a risk) is that the boundary between professional and personal relationships is difficult to locate, creating confusion for both the professional and the client over what is appropriate and what is 'crossing the line.' There is also the risk that comes from other providers interpretations of, and judgments about, an absent or unclear boundary.

In the fragmented, complicated, and often unresponsive long term care system from which most social workers come, the presence of an advocate is crucial. An advocate is important when services are requested of other individuals or organizations on behalf of the consumer. The social worker in this instance, comes to know a client well, is acutely aware of what the client needs, but is not in control of deciding which services the consumer will be given. Under these conditions the social worker and consumer become allies in a quest to obtain the desired services.

However, when the social worker is granted entrance to the entity making decisions about which services will be given to which consumers, the role of advocate becomes somewhat problematic. This mutual gatekeeping, advocacy role is considered by many to be untenable, as a significant conflict of interest.

### **Team Consequences of Social Worker as Advocate**

Continuing to define their role as 'advocate' has significant consequences for the functioning of a collaborative team. It keeps the social worker in a position of ally to the

consumer, as-opposed-to-and-up-against everyone else. This makes it difficult for social workers to become invested in the team since becoming a team insider requires a realigning of loyalties, and diminishing the commitment felt to the consumer. Thus, becoming a team member was experienced by early Partnership social workers as competing with loyalty to, and therefore ability to advocate for, the consumer.

Another consequence was the impact of this view on other team members. Accepting the social worker as 'the advocate' by implication suggested that other team members were not. Nurses objected to being perceived as other than advocates for their patients. They also responded that social workers could act as advocates for certain services and in certain arenas while nurses could act as advocates for other services and in other arenas. Identifying either as 'the' advocate would preclude effective advocacy in the other domains.

## **TEAM EVOLUTION**

The team went through an evolution that reflected the differences in ideology within the group and the larger organization as well. Attempts were made by team members and their colleagues to subvert the collaborative process in a variety of creative ways. Working against their efforts, however, was a structure that made the team, as a

team, accountable for the care provided and the necessity of group agreement for identifying and engaging necessary resources.

### **Team Subversion Strategies**

Initially, team members were quite insistent about resisting each others interpretations, while bolstering their own views with the support and validation of colleagues outside the team. Continuing to discuss cases primarily in non-team groups, especially when these interactions culminated in a decision about the care of a consumer, undermined the team process and prevented the disciplines from hearing each other. Some early efforts by the team to divide the work into social services and health care domains was reminiscent of the Compromise Model proposed by some during the planning phase. Under these conditions, team members did not feel it was necessary to either co-locate or meet frequently as a team.

One important parameter of team functioning was found to be the amount of time consumers were discussed with non-team members, in single discipline groups, compared with the amount of time that the same consumer was discussed with other team members, especially those in another discipline. The primacy of non-team conversations was promoted by the organization of office space, initially, into single discipline units. This organization both reflected and promoted separation of the disciplines. As collaboration

increased, both the interaction with other team members and the office space organization shifted.

A second parameter of team functioning was related to the first. In the beginning, team members had differences of opinion over which discipline should perform which assessments. In particular, areas in which the two disciplines overlapped were hotly contested. One outcome of this, initially, was that each discipline tended to perform its own assessments in these contested areas. This division of labor obviously results in redundancy. Even more significant, however, is that this repetition reflects the team's inability to integrate the domains, to rely on each other, and to respect each others' skills. The willingness to accept and base decisions about their own work on the other disciplines assessment was a significant marker of team evolution. During the awkward transition from primarily separate work to integrated team functioning there was some reluctance to accept the assessments of the other disciplines but disguised in various ways. Convenience or inconvenience was the reason most often given. Other reasons for not being able to use a team member's assessment tended to dissipate as integration and trust developed.

Another important parameter of team functioning was the timing and process of coming to a conclusion about what the consumer needed or what should be done. Early in the functioning of the team, decisions were often made prior to the team meeting. The

team did not at that time, function as a problem solving body, but as a place to argue over and advocate for decisions that had already been made. One of the most significant criteria of a well functioning collaborative team is how comfortable team members are waiting for the team forum to come to a conclusion about their own plan, without fear of being overwhelmed by the other discipline's plan. [Social workers were much more likely to feel overwhelmed by the health care providers, noting that they could be shut out of the conversation through the use of medical/technical language and trumped by claims about safety or urgency.]

One of the hallmarks of this divided labor and fragmented team is the ability to work 'well' without meeting and discussing individual consumers or using generic approaches to common problems. As the team evolved into a more collaborative work group, meeting frequency increased, reflecting the interrelated nature of team decisions and reflecting their interdependence. This was also reflected in the acceptance of each discipline as having relevance to most decisions. The comfort with which team members comment on the plans and ideas in areas generally seen as outside their domain (defined either by authority or knowledge) was another significant indicator of collaborative practice.

The increasing ability to anticipate and appreciate the contribution of the other discipline was an important indicator of team evolution. Team members became quite

adept, over time, at anticipating what the other discipline's focus would be on a particular problem. This eventually evolved into a real appreciation for the significance of asking these particular questions and a belief that their work could not be done as well without either the perspective or the information

One of the later shifts in the evolution of a collaborative team is both disciplines acknowledging that patient/consumer-centered care requires the approaches of both disciplines and an understanding of why. This appreciation is reflected in a shift in the questions being raised by members of each discipline in team forums. Questions that had been only asked by social workers in the past would be asked by nurses. Questions that were predictably asked by nurses would now, sometimes, be asked by social workers. An indicator of success at this point is the evidence that each discipline has incorporated the other's perspective into its own thinking.

At about the same time in the team evolution, the role of advocate becomes accepted as shared, a team role. The members at this point, begin to see themselves, and each other as advocates for a common outcome by bringing different expertise to bear on the problem. Nurses can advocate for community rather than nursing home care from a position of expertise on the healing of wounds. Social workers can suggest changes in medical treatment based on biographical knowledge about the patient that relates to the treatment plan.



## **OBSTACLES TO BUILDING A COLLABORATIVE TEAM**

In addition to the obstacles inherent in the disciplinary perspectives, several other obstacles were seen to undermine the development of a collaborative team.

### **New Team Members**

The ability to integrate health and social service perspectives was taxing for even the most expert, experienced providers from both disciplines. When a novice provider is placed on the team, the confusion over disciplinary boundaries, and the pull between being cooperative and pressing for a particular approach to care or the inclusion of a perspective, was overwhelming. Novice providers seemed to take on one of two approaches. First, some opted to be a 'good' team member which meant cooperating with and supporting other team members. Where novice social workers did this, the biographical expertise and the focus on broader quality of life issues that social workers generally bring to the discussion, tended to get lost. The consequence was a well functioning team that was not consumer-centered. When a nurse did this, standards of practice and good medical outcomes are jeopardized. Both are necessary elements in high quality care.

## **Organizational/Management Systems**

Another threat to the evolution of the team is a reporting system that maintains a disciplinary division from above. The danger here is that disputes between managers supervising team members can be played out within the team. Managers who encourage team members to return to the team for resolution of conflicts facilitate the growth and integrity of the team. Managers who commiserate with the team member only exacerbate the divisiveness. A single supervisor for the team, rather than separate supervisors for each discipline was observed to promote more effective team functioning. This, of course, requires a very skilled, experienced supervisor who does not promote divisions by supporting a particular philosophy or approach.

## **Risk Taking**

Other organizational influences that affected team functioning included general levels of stress and attitudes toward risk taking in general and litigation in particular. Both high stress and fear of risk taking promote a return to earlier, more divided, less integrated team functioning. The organizational attitude toward risk was seen to create a permissive or cautious tone for the team that clearly influenced team decision making. An even greater effect was accounted for by the shared nature of risk taking by the team. Individual members, nurses in particular, expressed a much greater willingness to take

risks that promoted patient choice when the decision had been made and supported by the team rather than entirely on their own. Shared accountability for decisions had a significant impact on patient choice and the possibility of consumer/patient-centered care.

### **Discipline Centered Team Members**

The inability to hear and appreciate the other discipline's contribution, to let go of the sense of primacy of their own discipline and approach, or to feel primarily responsible for the patient's well being all prevented the team from functioning collaboratively. Social workers who saw themselves and their discipline as the only one who really represented the patient's best interests and nurses who measured every decision by its potential risk were examples of this.

Overcoming this requires the ability of health care providers to view their recommendations in the larger context of the consumer's life in general. It requires that the social service providers view the consumers' general quality of life in relation to the health problems and related treatments.